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Implementing Hospital Autonomy in Jordan: Changing MOH Operating Procedures

March 2000

Prepared by:

Dwayne A. Banks, Ph.D.
Abt Associates Inc.

Rasha Ghannoum
Abt Associates Inc

Dr. Ayoub Sayyid Khalil As-Sayaideh, M.D.
Ministry of Health, Jordan

Dr. Abdel Razzac S. H. Shafei, M.D.
Ministry of Health, Jordan

Dr. Hani Brosk, M.D.
Ministry of Health, Jordan

Partnerships for Health Reform

PHR

Abt Associates Inc. ■ 4800 Montgomery Lane, Suite 600
Bethesda, Maryland 20814 ■ Tel: 301/913-0500 ■ Fax: 301/652-3916

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Abstract

Faced with declining resources and escalating operating costs for its health care services, the Ministry of Health (MOH) of the Hashemite Kingdom of Jordan is seeking ways to improve the relative efficiency of its publicly owned and operated hospitals. Granting limited autonomy (decentralization) to these institutions is one such approach. In April 1999 two pilot facilities were selected: Princess Raya hospital (in the Irbid health governorate) and Al Karak hospital (in the Al Karak Health Governorate). Since their selection, both hospitals have been engaging in Phase 2 of the decentralization process. In other words, workgroups at each hospital have identified various MOH operating procedures that should be amended or rescinded in order to achieve their short-run decentralization objectives. This document details the various short-run decentralization objectives and the methodology employed by the various workgroups in identifying and recommending changes in selected MOH operating procedures.

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Acronyms

DGABH	Director General of Al Bashir Hospital
DGCC	Director General of Curative Care
DGFA	Director General of Finance and Administration
DGHI	Director General of Health Insurance
DGPHC	Director General of Primary Health Care
JD	Jordanian Dinar
MOH	Ministry of Health
OLA	Office of Legal Affairs
PHR	Partnerships for Health Reform Project (USAID)
RMS	Royal Medical Service
USAID	United States Agency for International Development

Currency Conversion

JD 1 = US$ 1.41

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Finally, we would like to acknowledge the participation and support of our Ministry of Health and PHR-Jordan colleagues: Dr. Lonna Milburn, Ms. Runa Sindaha, Ms. Manal Shahrouri, Dr. Jamal A.A. Abu Saif, and Dr. Taissir Fardous.

Executive Summary

The Ministry of Health (MOH) of the Hashemite Kingdom of Jordan has expressed keen interest in granting at least partial autonomy to its MOH owned and operated hospitals. The Partnerships for Health Reform (PHR), a United States Agency for International Development (USAID)-sponsored project, began providing ongoing technical assistance during *Phase 1* of the Ministry's short-run hospital decentralization effort. Initial assistance was the sponsorship of a national workshop entitled "Hospital Autonomy in Jordan," held in Amman on 4 October 1998, at the behest of then Minister of Health, His Excellency Dr. Na'el Al-Ajlouni. The directors general of the health governorates, as well as the directors of all 22 MOH hospitals attended the workshop. During subsequent meetings between PHR and the Minister of Health, it was decided that the MOH would proceed with *Phase 1*. This entailed the selection of two MOH facilities for piloting hospital autonomy in Jordan. The hospitals selected were Princess Raya, in the Irbid governorate, and Al Karak, in the Karak governorate. Their selection, in April 19999, concluded *Phase 1*.

This report details *Phase 2* of the Ministry's short-run decentralization activities, in which PHR has been engaged over the past nine months. PHR's activities during this period had four overall objectives: (1) to establish "Reference Committees" and "Workgroups" within each pilot hospital; (2) to guide each pilot hospital towards achieving its targeted short-run decentralization objectives; (3) to facilitate the implementation of a detailed training plan, consistent with the expected needs of each pilot hospital; and (4) to facilitate the overall implementation of the short-run recommendations, as explicated by the hospital-based workgroups.

Background

In Jordan the governance of MOH hospitals is highly centralized. All significant managerial, budgetary, and procurement matters are ultimately decided by senior-level executives, located at the MOH headquarters in Amman. This has created a system in which the needs of hospitals and their patients frequently conflict with the policies of the central ministry. This has led many to speculate that MOH hospitals could be more efficiently operated, and the level of quality of patient care enhanced, if greater independence were granted to these institutions. In fact, hospital directors have overwhelmingly stated that greater independence over personnel, financial, and procurement matters is necessary for achieving targeted MOH cost containment objectives. A well-planned, carefully designed policy can take as long as 10 years to fully implement. Hence, Jordan's plan is divided into the implementation of short-run objectives and long-run objectives. Jordan is now completing *Phase 2* of its short-run objectives—that is, identifying existing MOH operating procedures to be amended or rescinded—in an attempt to provide greater managerial independence to the two decentralization pilot hospitals.

Phase 2 Activities

A workplan developed by PHR provided for the creation of two non-hospital-based committees to assist with *Phase 2* of the decentralization process: The first, the Hospital Decentralization Steering Committee, was made up of senior-level MOH personnel. It provided oversight and guidance of the

Phase 2 process and served as a liaison with the Minister of Health. The second, the PHR Implementation Team, led the overall implementation of *Phase 2* objectives.

The Implementation Team worked closely with staff at the two pilot hospitals, visiting the sites weekly in the period 24 May to 20 October 1999. In addition to educating hospital staff on the theory and applications of hospital decentralization in Jordan, the team guided hospital personnel through the following activities:

- Establishing a hospital-based "Reference Committee" in each hospital. The committees consisted of senior- and mid-level hospital staff. Their primary role was to provide overall guidance for the implementation of *Phase 2* objectives at their respective hospitals. In addition, the reference committees assigned senior-level hospital staff to hospital workgroups.

- Establishing three hospital-based "Workgroups" in each hospital, to prioritize, clarify, and suggest changes in MOH operating procedures that inhibit the hospital's performance. Each group had a particular focus: managerial, financial, or technical.

- Instructing workgroups on codes of conduct, voting procedures, and methods of communicating.

- Facilitating a six-week, onsite dialogue between the hospital workgroups and senior-level MOH administrative staff (directors of Finance and Accounting, Personnel, Procurement, Supply, and Training) who provided the workgroups with detailed consultation on the appropriate citations for the rules and regulations that currently determine MOH operating procedures. In addition, they assisted the workgroup chairmen in documenting and presenting to the Steering Committee their proposals for changes to MOH operating procedures.

- Assisting the chairman of the Steering Committee to draft a letter to the Minister of Health, which summarized the changes in operating procedures recommended by the workgroup.

Once these steps had been taken, the Implementation Team worked with the workgroups to develop a strategy to secure the support of key stakeholders for the recommended changes, and to prepare them for the changes. In addition to the practical education on hospital decentralization, the team developed a comprehensive training plan for key hospital and MOH personnel directly involved in the decentralization process. Key personnel at pilot sites of Princess Raya and Al Karak hospitals are currently undergoing intensive training in the areas of basic computer applications, hospital accounting, medical records, management, and finance. Having a cadre of hospital personnel trained in these areas will facilitate transition towards the short-run decentralization of these hospitals.

Workgroups' Recommended Procedural Changes

Among the most important accomplishments of *Phase 2* were the recommendations for changes to current MOH operating procedures made by workgroups at the two pilot hospitals. Workgroups were careful to suggest changes in the *application* of existing procedures, which are in the purview of the MOH, rather than more fundamental rewriting of Civil Service and other codes, which would necessitate legislative approval. Examples of recommended changes follow:

- Civil Service Code No. 1, Article 36, Paragraph (A), which deals primarily with the permanent placement and probation of new MOH employees: Workgroups suggested that hospital directors be given greater say in the permanent placement of personnel in their hospitals. Placement of more appropriately trained and experienced personnel will increase hospital efficiency by improving working relationships between employees and their supervisors, reducing hospital operating costs, and enhancing the quality of care provided to patients.

- Civil Service Code No. 1, Article 66, Paragraph (B), which deals primarily with the assignment and reassignment of hospital workers: Workgroups suggested that the hiring process be made more transparent and that hospital directors be given more authority in the process. Similar to the previous recommendation, this is expected to enhance worker productivity, provide employees with an incentive to engage in continuing education, and provide hospital directors with more managerial control over their institutions.

- Civil Service Code No. 1, Articles 113, 115, and 116, which deal with the establishment of training guidelines within MOH hospitals: Workgroups identified training needs so that hospital personnel will be able to handle new responsibilities implied by decentralization.

- Civil Service Code No. 1, Articles 132 and 133, which deal with the issue of "moral punishment penalties" and what hospital personnel perceive as unfair application of the articles: Workgroups suggested increasingly punitive measure for employees who violate codes of conduct, and also grievance procedures to which employees have recourse when accused of a transgression.

- Civil Service Code No. 1, Article 52 (A), which deals primarily with establishing internal MOH rules for employee performance evaluations: Workgroups suggested that reviews of many employees could be completed at the hospital level, rather than at the central ministry, and that well-defined indicators should be developed for each position and consider a broad range of employee accomplishments.

- General Supply Act No. 32, Article 16, Paragraphs (B) and (C), which detail the procedures for procuring supplies with values of JD 200 and greater: Workgroups suggested increasing the minimum expenditure over which hospital directors have discretion and mapped out procedures and timelines for emergency purchases. This will allow for the flexibility needed for optimal purchasing decisions and avoid the unnecessary delays that now occur. Such changes will lead to significant gains in hospital operating efficiency, timeliness, and quality of patient care.

- General Supply Act No. 32, Article 17, which deals primarily with the selection of members to the MOH Central Tenders Committee and subcommittees: Workgroups have recommended that the hospital director, or his appointed technical staff, participate in the technical subcommittee meetings. Such participation would allow the technical subcommittees access to expert technical opinions concerning the quality and efficacy of alternative hospital-based technologies.

- General Supply Act No. 32, Article 55, which deals with the disposal and resale of hospital-based equipment and supplies. Workgroups found current mechanisms cumbersome and costly. They suggested regular reviews to identify damaged or idle equipment and steps for prompt repair, transfer, or disposal. These changes will lead to better distribution of equipment and supplies, again, permitting better hospital efficiency and patient care.

- Transportation and Travelling Code, No. 56, Article 10, Paragraphs (A) and (B), which deal primarily with the compensation of employees in various "labor grades" for their transportation expenses when performing official MOH duties: While often overlooked, workgroups cited the inappropriate application of this article as a factor that adversely affects the productivity of hospital workers. Workgroups suggested that all grades of employee who incur work-related travel expenses be eligible for the travel allowance.

Conclusions

With the completion of *Phase 2*, the Ministry of Health has taken another step towards the decentralization of its network of publicly owned and operated hospitals. Workgroups at Princess Raya and Al Karak hospitals, collaborating with the PHR Implementation Team, identified key MOH operating procedures that should be amended or rescinded if short-run gains in the operating efficiency and worker productivity of their hospitals are to be realized. The majority of these procedural changes relate to the implementation within the MOH of various Civil Service, Supply Act, and Transfer and Travelling Act rules and regulations. However, prior to implementing many of the recommended changes, the MOH must consider several factors that mitigate the improvements in efficiency that the changes are expected to produce.

Firstly, several of the recommended changes require the establishment of new hospital-based committees, as well as impose additional responsibilities on the hospital director. Hence, the MOH, as well as the senior management within each hospital, must consider the additional workload that is to accompany their newfound authority. Secondly, several of these new responsibilities require that the affected personnel receive additional training in areas such as management, accounting, and finance. Therefore, prior to implementation of its short-run decentralization policies, the MOH must allow sufficient time for the establishment of a cadre of personnel sufficiently trained in each of these areas. Finally, it is imperative that each hospital establish a system for measuring its performance during the implementation of its *Phase 2* objectives. This can only be achieved if a hospital-specific performance measurement system is developed and enacted. Developing and enacting such a system is necessary to gauge whether or not the recommended changes will have their anticipated beneficial effects.

1. Background

The Hashemite Kingdom of Jordan is experiencing discouraging economic conditions—including recessionary growth rates, high unemployment, and declining real wages—that jeopardize public financing of health care services. As a result, officials of Jordan's Ministry of Health (MOH) must find ways to contain costs, while maintaining access to and quality of care, at the country's 22 public hospitals. In particular, the poor must be protected from any adverse effects of the drive for efficiency. One method by which the government may reconcile these ends is to grant hospital directors limited autonomy over managerial, budgetary, and procurement matters.

Giving hospital directors greater discretion over the establishment and implementation of rules and regulations that govern their daily operations should allow them to find efficiencies that reduce overall operating costs. Limited autonomy over managerial, budgetary, and procurement matters can contribute to cost containment in at least three ways. Firstly, for example, changing the rules that govern the allocation of labor (by type and quantity) in MOH hospitals may lead to more appropriate staffing patterns. Secondly, the method by which hospital revenues are collected and disbursed, along with the Ministry's highly centralized method of budgeting, denies hospital directors the flexibility they need to allocate resources efficiently; loosening the central control should allow directors to reallocate resources in a way that improves service efficiency and quality. Finally, the procurement and distribution of medical equipment and pharmaceuticals by hospitals is highly centralized and may not meet the needs of an individual institution; again, allowing some autonomy will allow hospital directors to procure the supplies that their facility needs.

Recognizing the cost-savings potential for granting hospital directors more independence over their daily operations, the then Minister of Health, His Excellency Dr. Na'el Al-Ajlouni, requested that the Partnerships for Health Reform Project (PHR) assist the MOH with the hospital decentralization process. PHR's collaboration with Jordan's short-term decentralization activities has manifested itself in three ways: Firstly, at the Minister's request, PHR organized a workshop on hospital autonomy on 4 October 1998. All 22 MOH hospital directors, directors general of the country's health governorates, and senior-level executives from the Royal Medical Services (RMS) and Jordan University Hospital attended (Muna 1998). The workshop provided attendees with needed information on the theory and objectives of hospital decentralization, with emphasis on the Jordanian context. Secondly, PHR established a Hospital Decentralization Selection Committee, which was assigned the task of recommending two pilot hospitals for implementing decentralization in Jordan. The two hospitals selected were Princess Raya, in the Irbid governorate, and Al Karak, in the Karak governorate (Banks 1999). The selection of these hospitals in April 1999 concluded *Phase 1* of the implementation process at which point His Excellency requested that PHR implement *Phase 2* of the decentralization process.

This report, which details *Phase 2*, is divided into nine sections. Section 2 provides an overview of the basic concept of hospital decentralization. Section 3 presents data on Princess Raya and Al-Karak hospitals. Section 4 discusses how and why workgroups and oversight committees were established at each pilot hospital. Sections 5 through 7 present the recommendations from the workgroups for changing MOH operating procedures in the areas of civil service, procurement, and staff transfer and travel. Section 8 presents a strategy for short-run implementation of *Phase 2* recommendations. Section 9 concludes the report with a summary of *Phase 2* achievements.

2. Hospital Decentralization

Many middle-income countries, such as Jordan, have come to realize that it is no longer economically feasible for the state to provide unlimited access to a full range of health care services to all of its citizens. As such, several of these countries are now experimenting with alternative methods by which services are both financed and delivered. One method is to grant limited operating autonomy to state owned and operated hospitals, with the belief that greater independence for these hospitals will lead to overall cost savings, while enhancing the quality of care delivered.

2.1 Basic Concepts of Hospital Decentralization

Hospital autonomy, or decentralization, defined in its broadest sense, is the granting to hospital administrators and governing boards of at least partial self-governance, including decision making over management, labor, financial, and procurement decisions. There exists no single form of hospital decentralization that is universally applicable across countries; rather, the form of hospital decentralization that is adopted by a country is determined by its social, economic, cultural, and political realities. There exists a spectrum of possibilities, from wholly government owned and operated hospitals, to fully independent institutions. In any event, the level of hospital decentralization granted to an institution can be gauged from two broad perspectives: 1) by the level of *ownership autonomy*, and 2) *functional autonomy* granted to an institution.

Ownership autonomy refers to the transfer of ownership rights, either in part or in full, from the government to non-governmental entities.[1] In other words, the level of autonomy (or decentralization) granted to individual hospitals is a function of the ownership rights they enjoy, vis-à-vis ministries of health. For example, full *ownership autonomy* would entail the complete transfer of hospitals' assets to the private sector. This is rarely done, however. Instead, the vast majority of governments continue to retain complete or majority ownership of their hospitals' assets. Hence, the greatest variation among countries that have engaged in the process of hospital decentralization is in the level of *functional autonomy* their governments have been willing to grant institutions.

Functional autonomy refers to, and is measured by, the level of independence granted to hospital managers in the following areas:

- **Administrative:** To what extent are hospital managers allowed and able to set their own administrative goals and objectives?

- **Managerial:** To what extent are hospital managers allowed and able to determine policies governing hiring and firing of personnel, procurement of equipment, drugs, and supplies, and establishing operating hours for their facilities.

- **Financial:** To what extent are hospital managers allowed and able to manage budgetary allocations, revenues generated, and expenditures? How much independence will hospital directors have over raising new revenues and the design of cost-recovery schemes?

[1] For an excellent overview of the issue, see Chawla and Berman 1996.

Hence, in the long run, the level of ownership and functional autonomy granted to MOH hospitals will determine the type and degree of hospital decentralization that is ultimately adopted in Jordan.

2.2 Implementation Strategy for Decentralization

The implementation process for granting greater autonomy to public hospitals in Jordan follows a pattern similar to that found in other countries, both developed and developing. The process is normally divided into two stages: the short-run and the long-run. In the former, the MOH identifies a set of short-run priority areas that are likely to have immediate beneficial affects on the hospital's operating efficiency. Typically, this entails changes in MOH operating procedures only. Hence, parliamentary or legislative review of the process rarely occurs. In the long run, however, the decentralization process becomes more complex, necessitating changes in government-wide rules and regulations (such as those of the civil service) and involving stakeholders from other ministries (such as finance) and governmental agencies. This often requires legislative changes or parliamentary decrees, and extends the time needed to achieve decentralization.

Two major factors to consider when designing an effective strategy for implementing hospital decentralization policy in Jordan are the following:

- To what degree will central political leaders and ministries other than the MOH support hospital decentralization? Changes in the vast majority of MOH rules and regulations (e.g., in hiring and firing, and in budgetary allocations) require changes in government-wide policies. For hospital decentralization to succeed it must have the political support of all those who are active in the design and implementation of health care legislation.

- How will the public view greater autonomy for public sector hospitals? To what extent does the public believe greater autonomy will lead to enhanced service quality, increased access and improvements in the operating efficiency of hospitals?

3. Princess Raya and Al Karak Hospitals

This section provides an overview of Princess Raya and Al Karak hospitals, the two pilot sites for Jordan's hospital decentralization program. The managerial, personnel, and budgetary constraints faced by these two hospitals are quite similar to those faced by the remaining 20 MOH owned and operated hospitals.

3.1 Princess Raya Hospital

Princess Raya hospital was established in 1995. The hospital is located approximately 120 kilometers north of Amman, in a hilly rural region of the Irbid governorate. Its patient population comes from the many nearby rural villages and towns. The hospital was recently selected as a United States Agency for International Development (USAID) Comprehensive Post Partum facility, and it has an active nurse training facility that is sponsored by the Italian government. Approximately 61 percent of the patient population is covered by the Royal Medical Services for both inpatient and outpatient services. Table 1 provides selected descriptive statistics about the Irbid governorate and the Princess Raya hospital.

Table 1. Descriptive Statistics for Irbid Governorate and Princess Raya Hospital

Irbid Governorate	
Total population in governorate	835,360
Unemployment rate	28.6%
Insured workers	59.2%
Comprehensive clinics	5
Primary health clinics	43
Peripheral clinics	14
Maternal and child clinics	35
Princess Raya Hospital	
Hospital Director	Dr. Ahman Al-Shugran
Physical size (m^2)	7,000m^2
Land area (m^2)	47,000m^2
Bed size	64
Occupancy rate	77%
Inpatient admissions	5,848
Average length of stay	3.1 days
Inpatient days	17,961
Outpatient visits	53,709
Health care coverage	
Percent insured	19.5%
Percent RMS	61.0%
Percent uninsured	17.8%
Staff	
Administrative	13
Physicians	29
Nurses	137
Ancillary	46

3.2 Al Karak Hospital

The original Al Karak hospital was established in 1956, approximately 145 kilometers south of Amman in the governorate of Al Karak. A new Al Karak hospital was built in 1996, approximately seven kilometers from the original site, as part of a Jordanian and Italian government cooperative. The new hospital has a USAID-funded Comprehensive Post Partum facility, as well as a nurses training facility sponsored by the Italian government. The hospital's former site is now used as its outpatient facility. Table 2 provides selected descriptive statistics of the Al Karak governorate and the Al Karak hospital.

Table 2. Descriptive Statistics for Al Karak Governorate and Al Karak Hospital

Al Karak Governorate	
Total population in governorate	188,600
Unemployment rate	32.3%
Insured workers	69.9%
Comprehensive clinics	5
Primary health clinics	34
Peripheral clinics	36
Maternal and child clinics	38
Al Karak Hospital	
Hospital Director	Dr. Sultan Tarawneh
Physical size (m^2)	8,500m^2
Land area (m^2)	60,000m^2
Bed size	110
Occupancy rate	62%
Admissions	8,781
Average length of stay	2.8 days
Inpatient days	24,795
Emergency room visits	20,442
Outpatient visits	58,581
Health care coverage	
Percent insured	4.2%
Percent RMS	45.7%
Percent uninsured	33.0%
Staff	
Administrative	19
Physicians	42
Nurses	244
Ancillary	56

4. Establishing Workgroups and Oversight Committees

Early in *Phase 2*, PHR developed a workplan to guide the decentralization activities during that period. The plan entailed the creation of several committees, with members drawn from the MOH and the pilot hospitals that would assume responsibility for the oversight and substantive work.

First, a Hospital Decentralization Steering Committee was formed to guide and oversee activities. Committee members, who represented the central ministry, governorate, and facility levels of the health system, were Dr. Ismail Saedi, Director General of Finance and Administration; Dr. Taher Abu Samen, Director of Planning and Projects; Dr. Suleiman Oweiss, Director General of Irbid Health Directorate; Dr. Abdullah Al-Shawawreh, Director General of Al Karak Health Directorate; Dr. Ahmad Shugran, Director of Princess Raya Hospital; and Dr. Sultan Tarawneh, Director of Al Karak Hospital.

On 19 May 1999, a hospital autonomy Implementation Team was formed. The team consisted of Dr. Dwayne Banks, PHR-Jordan Chief of Party; Dr. Hani Brosk, PHR-Jordan MOH Project Manager; Dr. Ayyoub S.K. As-Sayaiden, PHR-Jordan MOH Counterpart; Dr. Abdel Razzac S.H. Shafei, PHR-Jordan MOH Counterpart; and Ms. Rasha Ghannoum, PHR-Jordan Translator.

The Implementation Team made weekly site visits to the Princess Raya and Al Karak hospitals from 24 May through 27 October. The regular visits allowed the team to assist the pilot hospitals, first, to organize hospital-based oversight committees and workgroups that would guide hospitals towards the successful implementation of *Phase 2* objectives, and, second, to facilitate the work of the groups. The composition and roles of the groups are briefly described below:

- One oversight committee, known as a "Reference Committee," was established at each hospital; its members were senior- and mid-level hospital staff. The reference committees provided overall guidance for the implementation of *Phase 2* objectives at their respective hospitals. In addition, the committees assigned senior-level hospital staff to hospital workgroups.

- Three hospital-based workgroups were established at each hospital, each with a specific function: administrative, financial, or technical. Each was assigned the tasks of prioritizing, clarifying, and suggesting changes in existing MOH and government-wide rules and regulations that currently inhibit its hospital's performance.

To facilitate dialogue among the various workgroup members and to provide overall structure to their discussions, the Implementation Team conducted the following:

- Trained the workgroups on rules of conduct, voting procedures, and methods of communication, utilizing information obtained from the USAID Quality Assurance project.

- Facilitated a six-week, onsite dialogue between the workgroups and senior-level MOH administrative staff (i.e., the directors of Finance and Accounting, Personnel, Procurement, Supply, and Training). These senior staff provided the workgroups with detailed

consultation on the appropriate citations for the rules and regulations that currently inhibit hospital performance. In addition, they assisted the workgroup chairmen in presenting their policy proposals to the Steering Committee.

The Implementation Team also assisted the Steering Committee chairman to draft a summary letter to the Minister of Health that recommended changes in current operating procedures, based upon the documents submitted by the hospital-based workgroups.

5. Changes in the Implementation of the Civil Service Code

Like other government workers in Jordan, MOH personnel are civil service employees. Hence, the 1998 Jordanian Civil Service Code governs their daily work-related activities. Article 166 of the Code assigns ultimate responsibility for enforcing MOH-related provisions exclusively to the Minister of Health. However, it also allows the Minister of Health to delegate significant administrative responsibilities to the Secretary General of Health (often referred to as the Under Secretary of Health), who may then transfer selected responsibilities to directors general of the health governorates. Historically, however, this latter transfer of responsibility has rarely occurred. Hence, daily administrative responsibilities such as the hiring, firing, reassignment, promotion, and training of hospital personnel remain a highly centralized process. Needless to say, individual hospital directors have little managerial discretion in their own facilities.

In an effort to correct the inefficiencies that result from such a highly centralized system, the workgroup personnel at Princess Raya and Al Karak hospitals have suggested short-run changes in the *application* of the Civil Service Code at their institutions. They did *not* suggest changes in the Code itself, which would require a parliamentary decree, but administrative changes in the implementation of specific articles of the Code, as they apply to the MOH. This section identifies these articles, along with the recommended procedural changes.

5.1 Probation and Permanent Placement

According to Article 36 (A) of the 1998 Civil Service Code, a civil service employee shall be under probation for a period of three years, starting from the first full day of work.[2] This period, under special circumstances, may be extended for two additional years. However, if at the end of the third year the employee does not receive an official letter from the MOH indicating appointment to permanent employment status or an extension of the probation period, employment is terminated.

While the application of Article 36 (A) does not preclude qualified and efficient employees being assigned to permanent positions within hospitals, its application may have adverse consequences. Indeed, workgroups at both Princess Raya and Al Karak hospitals believe that current application often leads to the permanent placement of unqualified and inefficient employees in key positions. For example, the central ministry maintains the right to discontinue the employment of "non-permanent" employees with little or no feedback from the hospital director or the employee's direct supervisor.

This article also includes procedures for awarding overtime pay. Under current procedures, an employee initiates a request for overtime payment to his direct supervisor. The hospital director assesses the request and submits written comments to the director general of health for the

[2] Current procedures for hiring new employees is as follows: 1) new jobs are widely advertised, and applicants apply usually at the General Directorate; 2) prospective hires, after completion of the appropriate documents, are interviewed; 3) successful applicants are notified, via the local newspapers, and employment begins upon successful completion of all pre-employment procedures.

governorate. The director general then submits an assessment to the MOH "overtime committee," which approves or disapproves of the payment.

These decisions about permanent placement and overtime pay, conducted by senior management personnel so removed from the site and level of the employment, lead to decisions being made without adequate information about the employee or on the basis of factors unrelated to that employee's performance. This can lead to placement of inadequately trained or experienced employees or create perceptions of unfairness on the part of qualified employees. This may serve to inhibit the optimal performance of employees. Thus, to better serve their patient populations and to reduce the operating costs that result from the permanent placement of inappropriate employees within their institutions, the two workgroups proposed the following changes to the application of Article 36 (A):

- The hospital director should actively participate in the placement of permanent staff at the institution. For example, the director should determine the starting date of personnel assigned to the hospital, in coordination with the MOH Department of Personnel.

- The hospital director, the employee's direct supervisor, and a hospital-level administrative committee should determine which employees are eligible for permanent placement within a given hospital.

- The head of each hospital's personnel department should draw up an annual or bi-annual listing of all employees who have completed their probationary periods.

- Greater input from hospital directors or their representatives should be solicited when issues concerning overtime payment are discussed. A representative from the hospital should participate in meetings of the overtime committee.

In summary, the workgroups believe that the above modifications to the application of Article 36 (A) will lead to the placement of more efficient personnel and enhanced working relationships between employees and their supervisors, which will reduce operating costs and improve quality of patient care in their hospitals.

5.2 Employee Transfers

According to Article 66 (B) of the Civil Service Code, a hospital employee from the third or fourth labor categories (see Section 7 for discussion of labor categories) may request reassignment from one position to another, within the same hospital or from one governorate to another. The process of reassignment begins with a formal request from the employee to his immediate supervisor. The hospital director, based on input from the supervisor, writes a formal letter to the director general for health of the governorate to express agreement or disagreement with the transfer request. The director general, based on input from the hospital director and immediate supervisor, then makes a recommendation to the Minister of Health. The Secretary General of Health, based upon the recommendation of the Minister of Health, writes a formal letter of approval or disapproval of the transfer. (If this responsibility has previously been transferred to the Secretary General of Health, as determined by Article 166, the Secretary General may take this action unilaterally.)

According to the pilot hospital workgroups, this highly centralized process of approval or disapproval makes it more likely for personnel with the greatest influence to achieve their transfer. In particular, the central ministry may approve of such a transfer irrespective of the hospital's staffing

needs. As a result, hospital personnel frequently cite the inappropriate application of Article 66 (B) as a major factor in the maldistribution of labor within hospitals. Hence, workgroups proposed the following modifications to the current application of Article 66 (B):

- The level of education that an employee has obtained should be consistent with the position for which he or she is applying. In other words, only qualified personnel with proven expertise and education in a given discipline should be able to request transfer into a new position. Hence, the person's curriculum vitae should be shared with all affected parties prior to placement.

- For internal hospital level transfers, the employee must write a letter of request to an internal hospital committee. The committee then makes its recommendation to the hospital director. It is the committee's responsibility to ensure that the individual making the request is sufficiently trained for the position for which he or she is applying.

- The hospital director should have the authority to make the final decision to transfer an employee within the hospital into a new position, and to accept personnel earmarked for placement into his hospital from another governorate.

- When considering a hospital placement for newly hired MOH personnel, the MOH hiring committee should consult the affected hospital director as early as possible about the candidate's educational level, training and other factors that would affect their ability to perform the stated tasks. In addition, the personnel needs of the hospital should be taken into account. Again, this requires early consultation with the hospital director.

In summary, the workgroups recommended that hospital directors determine the assignment and reassignment of employees to their hospitals. While the current mechanism does provide employees with an avenue for requesting an internal transfer, it is extremely cumbersome and frequently results in a shortage or surplus of employees in key departments. Workgroups believe that modifying the application of Article 66 (B) will achieve the following benefits: worker productivity will increase, employees will have an incentive to engage in continuing education, the hospital director and the head of hospital personnel will have more managerial control over their institution, the reassignment of personnel will be based more clearly on the needs of hospitals, overall labor cost will be reduced, and improvements in the quality of care will be realized.

5.3 Training of Personnel

Articles 113, 115, and 116 of the Civil Service Code provide training guidelines for MOH personnel. These articles specify the conditions under which training shall take place, the selection of training candidates, their levels of compensation, and other parameters. The workgroups at Princess Raya and Al Karak hospitals stated that hospital personnel are often denied training opportunities, both domestic and international, due to the inappropriate execution of these articles. Moreover, for personnel who have received training, there exists little follow-up on the efficacy of the training or its applicability to their current work assignments. In addition, personnel selected and the training they receive is frequently inconsistent with the needs of the hospital. Workgroups suggested the following changes to the application of these articles:

- The hospital director, working with the hospital-based technical committee will draft the rules and regulations that are to govern the selection of candidates, as well as set the standards for reporting and follow-up with recipients of domestic or international training.

- The managers of each hospital department must submit the names of personnel and their training needs to the hospital director, on a quarterly basis.

- The hospital director, the department managers, and a hospital technical committee must provide a ranking of the training needs for their hospital on an annual basis.

- The technical committee is responsible for drafting a training plan for the hospital, to be submitted to the hospital director no later than October 1 of the year prior to its implementation.

- The technical committee, working with the hospital director, creates a training budget for the hospital, to be submitted to the MOH Director of Training.

In summary, the workgroups have identified the need for a more comprehensive and efficient system for managing the training of hospital personnel—one that is consistent with the provisions of Articles 113, 115, and 116. They have identified the need for more administrative, clinical, and technical training of personnel, as well as the need for establishing a system of follow up for personnel that have completed training programs.

5.4 Moral Punishment Penalties

Articles 132 and 133 of the Civil Service Code deal exclusively with the issue of "moral punishment penalties." Moral punishment penalties are imposed on employees from the second through fourth labor categories (see Section 7) who are suspected of violating Civil Service "codes of conduct." These include abuse of power or position, engaging in immoral acts, and/or engaging in unethical behavior. Enforcement of Articles 132 and 133 resides with the Secretary General of Health. When an employee violates a provision of these articles, his immediate supervisor writes a report to the hospital director, who then recommends to the Secretary General of Health a mode of punishment to the health governorate's director general; punishment may be a notice of action, warning, final notice, temporary reduction in salary, delay in annual wage increases, dismissal, or other measure. The Secretary General may unilaterally accept or reject the recommendation.

While Articles 132 and 133 provide a mechanism by which civil "codes of conduct" may be enforced and moral standards upheld, their current structure does not ensure fair and adequate application of the law. In order to increase fairness in the application of Articles 132 and 133, the hospital workgroups recommended the following changes to MOH enforcement rules:

- For minor offenses, as observed by the employee's direct supervisor, the following steps should be taken:

    - The employee's immediate supervisor must notify the hospital director in writing about the exact nature of the offense.
    - After consulting with the supervisor, and if deemed appropriate, the hospital director initiates follow-up action in the form of a formal *written warning* to the employee.
    - If the written warning fails to modify the employee's behavior, the hospital director may issue *written notice* of a pending temporary salary deduction.
    - If the notice fails to change the employee's behavior, a formal *salary deduction* is recommended to the MOH Director of Personnel.

- If the salary deduction fails, a delay in the upcoming years *annual pay raise* is recommended to the MOH Director of Personnel.

- An employee who suspects unfair treatment under Articles 132 and 133 is allowed to voice a grievance directly to the MOH Director of Personnel in writing or in person.

  - After assessing the issues, the Director of Personnel may investigate all actions taken by the hospital director in the case of an employee who claims to have been treated unfairly. If the Director of Personnel finds the claim to have merit, the employee is to receive compensation for wages lost and/or a formal letter of apology from the Director of Personnel. All formal notices and warnings are to be removed from the employee's personnel records immediately.

  - For major cases, as determined by the Director of Personnel, a neutral grievance committee must review the case. The Director of Personnel will appoint members of the committee.

In summary, workgroups expressed concerns about fairness in the application of Articles 132 and 133 of the Civil Service Code. The unfair application of its provisions has had significant effects on the productivity and morale of hospital employees and the quality of patient care rendered in various departments.

5.5 Annual Performance Evaluations

Article 52 (A) of the Civil Service Code provides the Secretary General of Health, or his designate, the necessary responsibilities for conducting annual performance evaluations of MOH personnel. Employees may receive overall evaluations of excellent, very good, good, medium, and weak. Current procedures for conducting performance evaluations in the MOH are as follows. Firstly, the employee's immediate supervisor drafts an evaluation report. Secondly, the hospital director reviews the supervisor's report. Finally, the health governorate's director general evaluates the overall commentary; if his approval is granted the report is transferred to the central ministry's personnel division. Depending upon the overall rating, the result of the performance review varies, from the awarding of an annual pay raise to dismissal from the MOH. For example, under Article 52 (A), an employee who receives a rating of "weak" is subject to a written warning by his supervisor. If after that warning the employee's performance does not improve, he or she may be forced to relocate to another facility. At the new facility, if the employee's performance does not improve, he or she is subject to dismissal.

Article 52 (A) is viewed by workgroups as essential to determining promotions, pay raises, and penalties. To increase the objectivity of the process and to promote fairness in its execution, however, they suggested the following amendments:

- Authority that Article 52 (A) currently delegates to the Secretary General of Health should instead be granted to hospital directors. In other words, this amendment would eliminate the need for directors general of health and the Secretary General of Health to review annual performance evaluations.

- Employees' extracurricular activities, such as continuing education, personal achievements, research activities, and workshop attendance should be taken into account during the performance evaluation.

- A uniformed, well-defined set of performance indicators should be adopted for all job categories. The measures should be uniform across MOH hospitals and structured in such a way that subjectivity in the evaluation process is minimized.

- An employee who chooses to challenge a performance evaluation must be guaranteed access to a "dispute resolution committee." This hospital-based committee must provide a written account of its overall assessment of the case. If the employee is dissatisfied with the results of the dispute resolution committee, he or she may then file a written grievance to the MOH Director of Personnel.

In summary, workgroups believe that amendments to the application of Article 52 (A) of the Civil Service Code are necessary for short-run decentralization efforts. Increasing the objectivity of the performance evaluation process, and creating a mechanism whereby personal achievements are routinely assessed will aid in enhancing health worker motivation and the quality of care within these institutions.

6. Changes in the Implementation of the General Supply Act

The General Supply Act of 1993 applies to all government agencies that receive their operating budgets from the government's general revenues. The General Supply Act stipulates the rules for procuring, storing, and maintaining supplies that are available to all government ministries. In particular, the General Supply Act deals with general purchasing rules, guidelines for domestic and international purchases, the structure of tenders, the administration of supplies (to include their receipt and inspection), warehouse record keeping and storage guidelines, the transfer sale and disposal of supplies, and the guidelines for donating or transferring supplies. In directing these issues, it specifies the duties and responsibilities of executive and managerial personnel at each stage of the procurement process. In addition, the General Supply Act provides detailed rules and regulations governing the dispensation of government procurement funds among ministries, as well as the amount of discretionary—procurement-related funds—that are to be made available to various MOH executives and managers.

6.1 Procurement of Supplies

Article 16 of the General Supply Act, paragraphs (B) and (C), describes the procedures and authorities granted to hospitals for procuring supplies with a value of JD 1000 or less. Currently, paragraph (C) allows hospital directors discretion over expenditures of JD 200 or less. Purchases worth JD 201 to JD 1000 must be made through a MOH-appointed, three-member procurement committee.[3] However, paragraph (B) of the General Supply Act grants the Secretary General of Health discretionary authority to purchase supplies of value up to JD 500, on behalf of hospital directors.

More specifically, the current mechanism for purchases of JD 200 or less is as follows. Upon notification that an item is unavailable from the contracted supplier, the hospital director submits a purchase order to the general supply warehouse in Amman. If the item is unavailable at the warehouse an approved purchase order for an alternative vendor is provided to the hospital director by the MOH Director of Procurement. The vendor receives payment upon approval by the MOH Director of Finance and Accounting.

Current MOH procedures for approving purchases of JD 201 to JD 1000 are equally convoluted and inefficient, and rarely conducted in a timely fashion.[4] This expenditure category normally covers daily equipment maintenance and repair. The procedure is as follows: Firstly, the hospital director

[3] The composition of this committee is described in Article 16, paragraph (A), item 2: The committee must consist of three employees from the MOH, appointed by the Minister. The highest ranked or most senior member is to be appointed chairperson of the committee. Members' tenures shall not exceed one year, and all voting is to be conducted according to majority rules.

[4] For example, a blood-gas device has been out-of-order for the past two years at Princess Raya hospital. A MOH engineer observed that the devise was in need of a CO_2 gas regulator, priced at JD 450 ($630.00). However, by the time approval was granted for purchasing the device, the total repair cost had soared to JD 3200 ($4,480), due to the additional damage caused by operating the device without a regulator.

submits a written request to the director general of the health governorate, who may then forward the request to the MOH. Secondly, if the request is forwarded, a representative of the Secretary General of Health conducts an onsite assessment of the hospital. Thirdly, the representative's report is forwarded to a MOH technical committee. This committee forwards its recommendation to the Minister of Health, who then approves or disapproves of the purchase request. Fourthly, the technical committee drafts a "request for proposals," with the contract being awarded to the lowest bidder—taking into account the opinion of the technical committee. Finally, a MOH "receiving committee" is formed. Its function is to establish the terms for receipt of the services or supplies from the vendor. The vendor (supplier) receives reimbursement for his services once the Director of Finance and Accounting approves the appropriate invoices.

The workgroups at Princess Raya and Al Karak hospitals have found the current rules and regulations that govern discretionary spending by the hospital director to be inefficient and inadequate based upon the daily needs of their institutions. To make this process more efficient and timely, the workgroups suggested the following modifications to implementing the aforementioned provisions of the General Supply Act:

- The hospital director shall be granted discretion over expenditures of JD 500 or less, rather than having to work through the Secretary General of Health.

- A hospital director, upon notification that a contracted supplier does not have a particular item in stock, shall contact the MOH Directorates of Supply and Procurement to inquire about its availability at the central warehouse. If the item is not in stock, a purchase order shall be faxed directly to the relevant directorate for approval or disapproval. If approval is granted, the signed document shall be faxed within three days to the hospital director.[5]

- The hospital director, upon receipt of the approved faxed or original purchase order, initiates purchase of the relevant item with an alternative vendor within 24 hours.

- Under Article 16, paragraph (C), item 2, a tripartite MOH committee may allow the hospital director to purchase supplies of JD 1000 or less. Currently, the formation of this committee is done under the authority of the Secretary General of Health. The hospital workgroups recommended that this authority be transferred to the directors general of the health governorates.

In summary, the workgroups believe that significant gains in hospital operating efficiency, timeliness, and quality of patient care can be achieved if the aforementioned changes to the implementation of Article 16 provisions were to take place. The current structure of procurement does not allow the level of flexibility needed for optimal purchasing decisions, and oftentimes leads to unnecessary delays in the process.

[5] The exception being the case of emergency purchases. Under such circumstances the approved purchase order shall be returned to the hospital director within 24 hours.

6.2 Procurement of Services and Equipment

Article 17 of the General Supply Act provides guidelines for the establishment of a Central Tenders Committee within the MOH Directorate of Supply. The Central Tenders Committee carries out the task of establishing standards, guidelines, and recommendations for the procurement of services and equipment on behalf of the MOH. The committee consists of three full-time members[6]: a chairman, appointed by the Minister of Health; and two outside members, from the Ministries of Finance, and Industry and Trade, each of whom is appointed by their respective minister. Each member serves for a maximum of three years.

To facilitate optimal purchases on behalf MOH hospitals, the Central Tenders Committee is authorized to form technical subcommittees. Technical subcommittee members are selected from the Directorates of Supply and Procurement. Their tasks are to ensure that items purchased are consistent with the technical needs of MOH facilities. However, hospital workgroups have voiced concerns about the efficacy of the technical subcommittees. For example, subcommittee members frequently lack the technical expertise needed to make optimal purchases. As a result, the technical specifications of purchased items are often inconsistent with the needs of their hospitals. In addition, the committees are responsible for awarding contracts to private sector companies that perform daily support services, such as janitorial and security. Therefore, given the level of import of the technical subcommittee in supplying needed technologies and services to hospitals, the workgroups recommended that the hospital director, or his appointed technical staff, participate in the technical subcommittee meetings. Such participation would allow the technical subcommittee access to expert technical opinion concerning the quality and efficacy of alternative hospital-based technologies and daily support services.

6.3 Disposal and Resale of Equipment and Supplies

Article 55 of the General Supply Act delegates to the Secretary General of Health the authority to dispose of any unusable or damaged hospital equipment or other supplies. It is incumbent upon the Secretary General of Health to assess the usability or excess supply of all pending items. This shall be done under the auspices of a three-member committee appointed by the Secretary General. This committee must certify whether or not the targeted items shall be earmarked for permanent disposal or resale. The final decision is forwarded, in written form, to the Director of the General Supplies Department.

The workgroups at Princess Raya and Al Karak hospitals have found the current mechanism for the disposal and resale of equipment and supplies to be cumbersome and costly. At times the process has taken several months. In addition, due to the lack of sufficient storage space at these hospitals, re-saleable items are oftentimes damaged by exposure to weather and human tampering. The current mechanism for disposal of unneeded equipment and supplies is as follows: 1) the hospital prepares a list of items earmarked for disposal; 2) this list is forwarded to the director general of the health governorate, who then forwards his recommendation to the MOH; 3) the MOH inspects the items earmarked for disposal and forwards its recommendation to the Secretary General of Health; 4) if approved, the Secretary General of Health must convene a three-member committee with

[6] Voting within the Central Tenders Committee is conducted according to majority rule, with a quorum consisting of full membership participation. The Minister of Health makes the final decision regarding purchases that are recommended by the Central Tenders Committee.

representatives from the Ministry of Finance (MOF) and the MOH accounting department; and 5) this three-member committee must write a final report that approves of the disposal. To make the process more efficient and timely, the workgroups suggested the following modifications to implementation of Article 55:

- Hospital department heads should submit a listing of all damaged and idle hospital equipment, to the hospital director on a monthly basis.

- The hospital director, along with a three-member committee of hospital personnel, should conduct a visual inspection of the relevant equipment and prepare a written report of their findings and recommendations.

- The hospital director, on a quarterly basis, should present the committee's recommendations for the disposal of unneeded items to representatives of the MOF and the MOH Department of Finance and Accounting.

- Representatives of these organizations must state in written form, within three weeks, their concurrence or disagreement with the disposal request.

- The MOH shall make provision to rid the hospital of all items earmarked for disposal, within two weeks of the hospital director receiving final notification from the MOF and the MOH Department of Finance and Accounting.

In summary, storage and disposal of hospital-based equipment and supplies is an ongoing matter for Princess Raya and Al Karak hospitals. The need to dispose of idle and damaged equipment in a timely fashion is necessary for improving facility storage capacity. In addition, idle equipment may be earmarked to other MOH hospitals that may exhibit a greater need for such equipment. Hence, the aforementioned changes to the implementation of Article 55 may lead to more efficient distribution of equipment and supplies among MOH hospitals.

7. Changes in the Implementation of the Transfer and Travelling Act

The Transfer and Travelling Act of 1981 is constitutionally mandated. Its provisions are organized and enforced by the Ministry of Finance. It describes in detail the various rules and regulations that govern the transfer and travel of civil service employees, and it classifies civil service employees into categories and grades. There are four major "labor categories" within the Jordanian civil service. Each labor category has several subcategories, or "labor grades." In descending order of authority, the categories and their respective grades are: Category 1 (distinctive, first and second grades), Category 2 (distinctive, and first through sixth grades), Category 3 (first through tenth grades), and Category 4 (no unique grades). An employee's labor grade, not labor category, determines his or her eligibility for the transportation allowance.

7.1 Transportation and Travelling

The Transportation and Travelling Code, No. 56, Article 10, paragraphs (A) and (B) describe the transportation allowance to which eligible government employees, including MOH personnel, are entitled when conducting official MOH duties. Employees in the distinctive, first, second, and third labor grades are eligible for the allowance, in amounts ranging from a high of 80 JD per month (for grade 1) to a low of JD 25 per month, for grade 3. An eligible employee submits his or her request to the immediate supervisor, who forwards the request to the hospital director. The hospital director adds comments and forwards the final request to the Ministry of Health for approval.

Hospital decentralization workgroup personnel cited several problems with current MOH operating procedures, vis-à-vis Article 10. Firstly, provisions are not fairly applied to all employees. For example, approval of the allowance is perceived as being based upon familial and clan alliances. Secondly, distance and geographical location are not taken into account when setting the appropriate travel allowance. Finally, only certain categories of employees are eligible for Article 10 allowances; others are not, although they may incur job-related expenses. For example, all Category 4 employees (e.g., low wage earners and unskilled workers), and lower grades from other categories are ineligible. To ameliorate these problems and to increase fairness in the application of Article 10 allowances, the workgroups recommended the following changes to Article 10:

- Hospital boards for determining the eligibility of personnel for Article 10 allowances should be established. This board would make a recommendation to its respective hospital director.
- Actual miles traveled should be taken into account when estimating Article 10 allowances.
- Article 10 should be amended to make Category 4 and other currently ineligible employees eligible for travel allowances commensurate with their duties.

Workgroup personnel believe that significant benefits can be derived from the aforementioned modifications. Benefits include the following: 1) individuals who deserve travel allowances will more likely to receive them; 2) MOH vehicle maintenance cost will be lowered significantly; 3) payment

will more closely reflect the actual travel cost incurred by employees; 4) travel allowances will be allocated with greater fairness, and 5) employee productivity will be enhanced.

8. Short-run Implementation Strategy for Decentralization

The changes recommended for the implementation of rules and regulations of the Jordanian Civil Service Act, General Supply Act, and the Transfer and Travelling Act require the establishment of an effective implementation strategy. The hospital decentralization Implementation Team, in collaboration with the various workgroups at Princess Raya and Al Karak hospitals, structured the following strategy:

- Identify key MOH stakeholders who will be directly involved in the implementation process;
- Educate stakeholders on the particulars of hospital decentralization;
- Directly involve stakeholders in the implementation process; and
- Secure the signatory approval of documentation by key MOH officials.

8.1 MOH Hospital Decentralization Stakeholders

Any policy reform as complex as hospital decentralization involves the participation of several stakeholders. These stakeholders reside both within and outside of the MOH. However, the involvement of any particular stakeholder is ultimately determined by the extent of decentralization being proposed. Currently, the MOH is engaging in its short-run decentralization effort; hence, the proposed changes are simply procedural changes within the current regulatory structure. In other words, the MOH is *not* suggesting legislative changes or parliamentary decrees but instead the participation of several MOH stakeholders to optimally facilitate short-run implementation. It was essential for the Implementation Team to identify key MOH personnel likely to influence the implementation process. The team divided these key stakeholders into three tiers. Their roles and influence in the decentralization process are described below:

First-tier Executives

- ***His Excellency the Minister of Health****:* The Minister of Health is the highest-ranking governmental official within the MOH. As a member of the Prime Minister's cabinet, he provides overall vision and direction to the government in all aspects of health care policy. As a result, he is at the forefront of any health care reform, including hospital decentralization. Furthermore, the vast majority of recommended procedural changes enumerated in this document require the approval and counsel of the Minister of Health. For example, Article 166 of the Civil Service Code allows the Minister of Health to delegate a significant share of his responsibilities to subordinate executives within the MOH. Hence, his support and guidance is this effort is crucial.

- ***The Secretary General of Health***: The Secretary General of Health is the second most influential senior executive within the MOH. He influences virtually every sphere of decision making within the ministry. For example, the Secretary General of Health's responsibilities include the reassignment, classification, evaluation, and disciplining of all hospital-based employees; the overall management of hospital equipment purchases; the approval or disapproval of hospital level discretionary expenditures; and the training of all hospital personnel. Hence, his support and guidance is essential for successful implementation of any health policy reform in Jordan.

Second-tier Executives

- ***Director General of Finance and Administration***: The MOH Director General of Finance and Administration (DGFA) plays a pivotal role in the success of any MOH hospital decentralization effort. Key MOH directors (i.e., of Personnel, Finance and Accounting, Supply, Procurement, Building and Maintenance) are under his supervision. Therefore, the DGFA must be consulted for any policy that requires changes in the implementation of MOH administrative or financial procedures. Moreover, unlike other second-tier executives, the DGFA has traditionally enjoyed a direct line of communication with the Minister of Health.

- ***Directors General of Health Governorates:*** Each of Jordan's health governorates has a director general. As the primary liaisons between the hospital directors in their governorates and the central ministry, the directors general exert significant influence on daily hospital operations. As illustrated in Sections 5 and 6, all hospital requests—for specialized labor, equipment purchases, employee evaluations, and myriad other daily administrative issues—bound for the central ministry, must first pass through their hands. Hence, functions are first evaluated by these directors general.

- ***Director General of Curative Care***: The Director General of Curative Care (GDCC) is responsible for the training of all hospital personnel, the development and enforcement of government-wide prescription drug policies, and the regulation of blood banks and psychiatric hospitals. Key MOH directors (i.e., Training, Health Professions, Nursing, Drug Policy, the Central Laboratory, and Specialized Centers) are under the supervision of the GDCC. Hence, the GDCC must be consulted when designing or implementing training plans for hospital personnel involved in the decentralization effort, as well as any policy that involves changes in the dispensation of hospital-based pharmaceuticals.

- ***Director General of Primary Health Care***: The Director General of Primary Health Care (DGPHC) is responsible for a vast array of MOH policies. These policies include, but are not limited to, the overall management of most USAID- and other donor-funded health care projects, disease control, food inspection, health and safety, school health programs, and maternal and child health projects. In fact, key MOH directorates, such as the Directorates of Planning and Projects, Disease Control, Food and Hygiene, Environment, Health and Safety, School Health, and Maternal and Child Health are under DGPHC supervision. Of all directorates, the Directorate of Planning and Projects has most significance for the MOH's hospital decentralization efforts. For example, its director actively participates in the design and implementation any health care policy that affects hospital decision making and serves as the key consultant to the DGPHC on such matters.

- ***Director General of Al Bashir Hospital:*** The influence of the Director General of Al Bashir hospital (DGABH) extends far beyond the confines of this hospital in Amman.

Experienced, well-respected, and influential MOH executives have traditionally occupied this position. In addition, the DGABH serves as the liaison between the chiefs of specialties[7], most of whom are located within Al Bashir hospital, and the Minister of Health. Hence, his overall influence on MOH policies has the potential to affect hospital policy throughout the MOH. Furthermore, the DGABH and his chiefs of specialties have traditionally enjoyed direct communication with the Minister of Health.

Special-tier Executives

- ***Director General of Health Insurance***: The Director General of Health Insurance (DGHI), while not directly affected by any short-run hospital decentralization effort, has significant influence on the decision making of the Minister of Health. In fact, he has direct access to the MOH. The DGHI is often a well-respected MOH executive, with extensive years of experience at each level of MOH administration. For example, it is not unusual for the DGHI to have occupied the post of Director of Planning and Projects, as well as a hospital directorship at sometime during his career. Hence, this senior-level executive provides a wealth of information on MOH operating procedures.

- ***Office of Legal Affairs:*** The Office of Legal Affairs (OLA) provides overall guidance on the government of Jordan's legal rules and procedures to the Minister of Health. It is the OLA that the Minister of Health must consult concerning proposed changes in MOH operating rules and procedures, as well as the interpretation of the Civil Services Code.

8.2 Education and Participation of Key Stakeholders in the Decentralization Process

The PHR Hospital Decentralization Implementation Team has developed an effective plan to familiarize key MOH stakeholders with the particulars of hospital decentralization in Jordan. In addition to the nationwide educational workshop held on 4 October 1998, the following education and participatory policies have been initiated:

- The Implementation Team has made it a priority to brief and involve all ministers of health about the objectives of the hospital decentralization in Jordan. As a result, the team has consistently received utmost support from the past four ministers.[8]

- Key stakeholders (i.e., the Director General of Finance and Administration, the Director of Planning and Projects, the directors general of the Irbid and Al Karak governorates, and the directors of Princess Raya and Al Karak hospitals) have been active members of the Hospital Decentralization Steering Committee over the past year.

- A special committee of MOH executives, including the directors of the Departments of Personnel, Finance and Accounting, Supply, Procurement, Building and Maintenance, and Training, have served as special advisors to the Implementation Team. Each director made several visits to Princess Raya and Al Karak hospitals to provide special consultation on

[7] The MOH has a chief of specialty for each of the medical specialties (such as general surgery) and several sub-specialties within the MOH. Each chief provides overall guidance on practice guidelines and procedures regarding their specialty to the MOH. Hence, the chiefs of specialties are some of the most influential physicians within the MOH.

[8] In the past year and one half, Jordan has had four ministers of health.

interpreting existing rules and regulations that fall within the jurisdiction of their departments.

- In an attempt to provide a "real world" view of the challenges and effects of hospital decentralization, PHR sponsored a 10-day study tour to Tunisia for key MOH stakeholders.[9] Representatives from the Directorates of Finance and Administration (i.e., the directors of Procurement, Personnel, Finance and Accounting, Supply, and Building and Maintenance), the Director General of the Irbid governorate, and the Director General of Health Insurance attended this study tour.

Training of Hospital Personnel

Realizing the need for training in various areas of importance to a partially decentralized hospital, PHR implemented an intensive and detailed training agenda for selected personnel at both Princess Raya and Al Karak hospitals. This training plan included, but was not limited to, the following courses and other training activities:

- English language: Given the pervasiveness of the English language in health care policy, management, finance, and accounting, building English language proficiency provides hospital personnel access to information that will assist them in improving their job performance.

- Computer skills development: Computer skills enhance a person's ability to access information, and to communicate within the Jordanian health system and with an expanding global society. In addition, building capacity within this area also facilitates communication within the hospitals themselves.

- Management, finance, and accounting: These skills are needed for hospital personnel to optimize their new managerial and financial independence.

- Procurement of drugs and medical devices: Even the current limited nature of hospital decentralization in Jordan entails some decentralization of the procurement processes. To provide the pilot hospitals the necessary training, PHR sent selected personnel to a "state-of-the-art" procurement course in South Africa, from 20 August to 5 September 1999.

- Medical records technology: In an attempt to enhance administrative processing within each pilot hospital, PHR is actively involved in improving the administrative capacity of the medical records departments. Medical records personnel are undergoing extensive state-of-the-art training in this area.

- Observation of hospital decentralization: In order to make the decentralization issues and options more apparent to senior-level MOH executives and administrators, PHR sponsored a hospital decentralization study tour to Tunisia, 20-29 January 2000. Tunisia has successfully implemented a policy of decentralization for its network of government owned and operated hospitals.

[9] Tunisia has implemented a very successful decentralization of its system of publicly owned and operated hospitals. The system has decentralized managerially, administratively, and financially. As an Arab country with an economic, social and religious structure similar to that in Jordan, Tunisia serves as an outstanding model.

8.3 Implementation Document

Working with the Director of the Office of Legal Affairs and in consultation with other key MOH officials (i.e., the Director General of Finance and Administration and the Director of Personnel), the Implementation Team has drafted the necessary documentation to implement the procedural changes as described in Sections 5 through 7 of this report. This draft document was forwarded to the Director General of Finance and Administration (DGFA), who also chairs the Hospital Decentralization Steering Committee. The DGFA submitted the draft to the Steering Committee for review and commentary. Once it has completed its reviews, the Steering Committee will forward its comments to the Secretary General of Health for further comment. After the Secretary General's comments have been incorporated, the document will be considered final and submitted to the Minister of Health for signature.

8.4 Next Steps in the Implementation Process

Prior to and/or during the implementation of the procedural changes that emerged during *Phase 2* and have been outlined in this document, several issues must be considered by personnel at Princess Raya and Al Karak hospitals as next steps towards their long-run objectives of partial decentralization:

- It is imperative that each hospital has in place a cadre of staff trained and able to handle the new responsibilities they will have as the procedural changes recommended during *Phase 2* are implemented. As previously discussed, PHR is assisting in this effort through the intensive training program discussed above in Section 8.3. This is an ongoing process that the MOH must be willing to support in both the short and long run.

- Hospital workgroups have suggested that in the long run a hospital-based "board of directors" (or similar governing body) must be created at both Princess Raya and Al Karak hospitals. All personnel agree that the creation of such a body is likely to be complicated and arduous. However, the hospital reference groups have developed the following preliminary criteria to consider when selecting board members,[10] and in determining the function of such a body. At minimum, the board's function should include the following:

    1. Facilitate overall implementation of *Phase 2* objectives;
    2. Assist in the design of internal rules and regulations for the hospital;
    3. Ensure that only qualified medical staff are placed at the hospital;
    4. Assist the hospital's senior administrative staff in contractual negotiations with suppliers, and purchasers of hospital services (e.g., self-insured firms);
    5. Assist in conflict resolution;
    6. Assist in the procurement of equipment and supplies;

[10] Membership on the board of each hospital should be viewed as a public service. In addition, there should be full disclosure of each board member's formal and informal relationship with the hospital. Moreover, safeguards must be established to ensure that transactions between board members and the hospital are just and reasonable. Hence, board members must be selected in such a way to ensure that they recuse themselves from situations that present conflicts of interest.

7. Assist in the overall operation of the hospital, in such a way that patients' quality of care is enhanced;

8. Assist the MOH in the selection of the hospital director. It is the board's responsibility to select the most competent senior administrator for the hospital. The individual selected must display the competence and character necessary to maintain the highest standards of patient care.

> Workgroups at Princess Raya and Al Karak hospitals have developed preliminary organizational charts that depict each hospital's expected organizational structure within a decentralized MOH hospital system (see Annex B).

> The hospitals must conduct a survey of staffing requirements. This is of import, given that the current allocation of staff within each hospital is currently viewed as being suboptimal. This survey will also assist the MOH Director of Finance and Accounting in estimating overall budgetary requirements for each hospital.

> The hospitals must conduct a facility-level cost analysis. In addition to assisting the Director of Finance and Accounting in estimating an overall budget for each hospital, a facility-level cost analysis will provide the hospital director with important information on the relative efficiency of various cost centers within the hospital.

> Finally, each hospital must establish a system for measuring its performance during the implementation of its *Phase 2* objectives. This can only be achieved if a hospital-specific performance measurement system is developed and enacted. Developing and enacting such a system is needed to gauge whether or not the recommended changes have their anticipated beneficial impact.

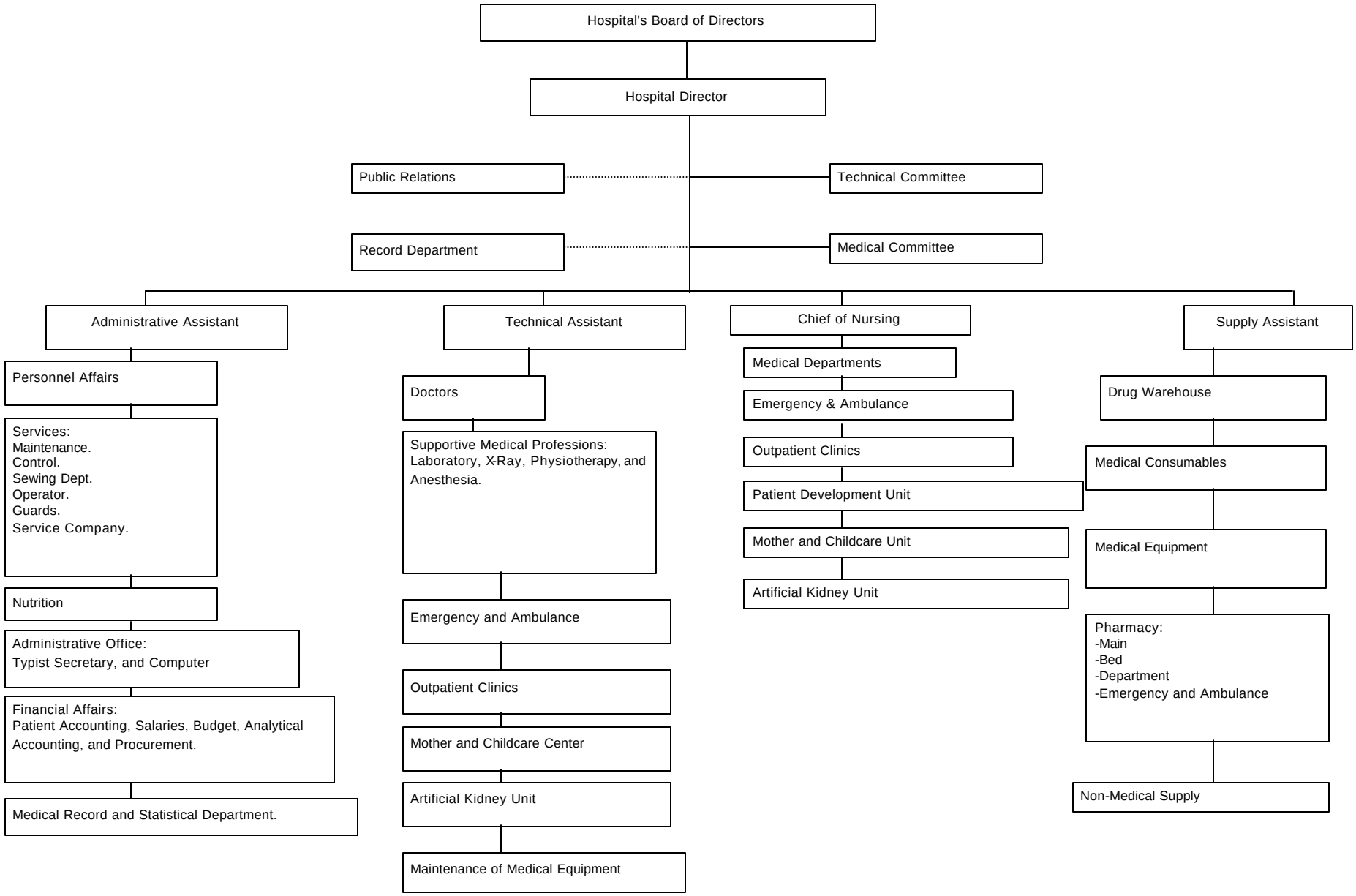
9. Conclusion

The Jordanian Ministry of Health has taken another step towards the decentralization of its network of publicly owned and operated hospitals. The first step in that process entailed the selection of Princess Raya and Al Karak hospitals as pilot institutions. These institutions, working with the PHR Hospital Decentralization Implementation Team, have identified key MOH operating procedures that should be amended or rescinded if short-run gains in the operating efficiency of their hospitals are to be realized. The majority of these procedural changes relate to the implementation within the MOH of various rules and regulations of the Civil Service Code, the General Supply Act, and the Transfer and Travelling Act. Workgroups at Princess Raya and Al Karak hospitals have associated these changes with potentially enhancing the overall operating efficiency of their hospitals, and the level of productivity of their workers. However, prior to implementing many of the recommended procedural changes, the MOH must consider two factors that are likely to influence the relative efficacy of these short-run policies.

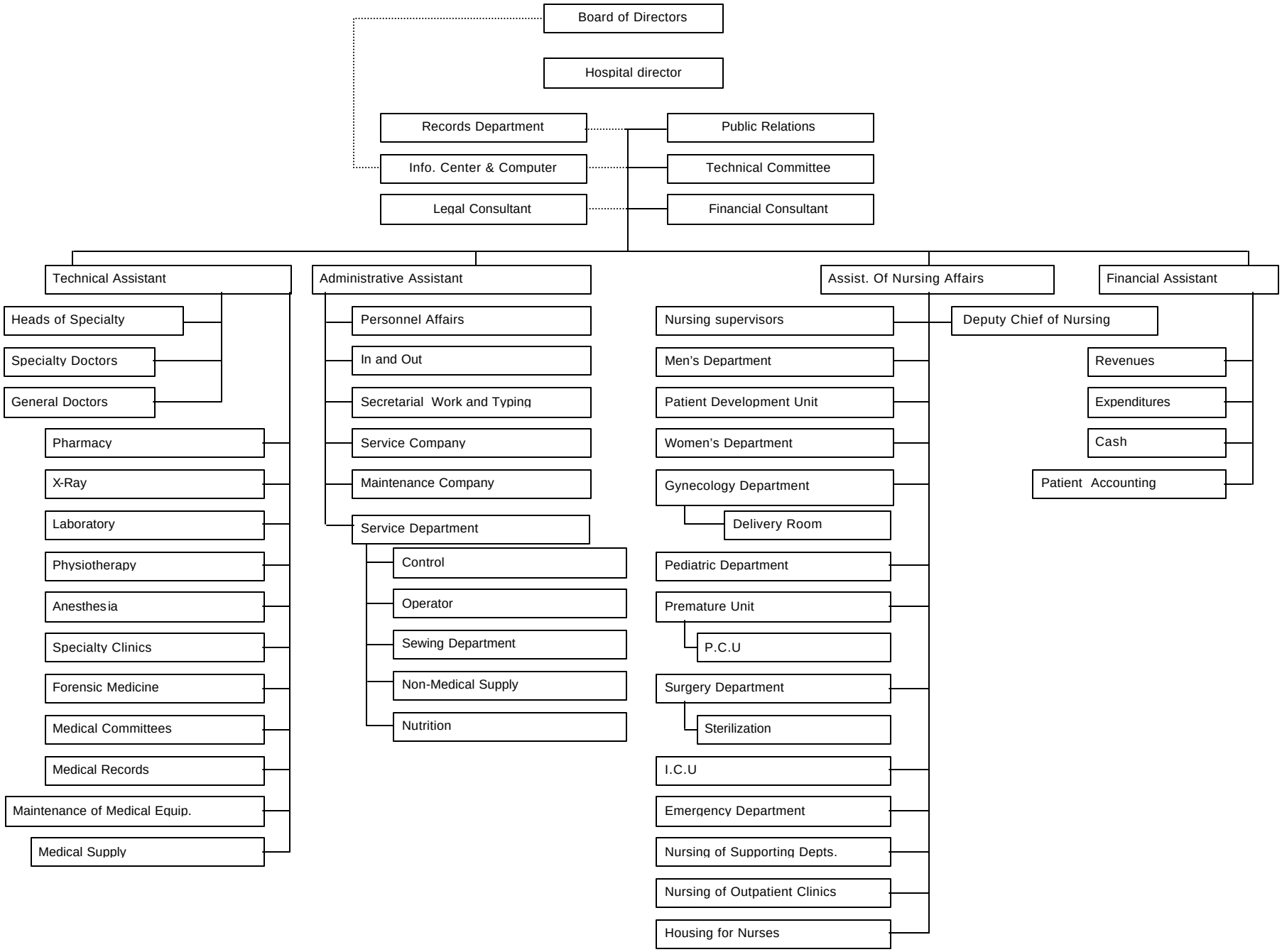
Firstly, several of the recommended changes require the establishment of new hospital-based committees, as well as the assumption of new responsibilities by the hospital director. Hence, the MOH, as well as the senior management within each hospital, must consider the additional workload engendered by these new responsibilities. Finally, several of these newfound responsibilities require that the affected personnel receive additional training in areas such as management, finance, and accounting. Therefore, prior to implementation of its short-run decentralization policies, the MOH must allow sufficient time for the establishment of a cadre of personnel sufficiently trained in each of these areas.

Annex A. Suggested Organizational Charts for Princess Raya and Al Karak Hospitals

Princess Raya Hospital



Al Karak Hospital



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